

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032938

Facility Name: THE ARC OF JACKSONVILLE LTD

Address: 1320 TENDICK JACKSONVILLE 62650
Number City Zip Code

County: MORGAN

Telephone Number: (217) 243-2405 Fax # (217) 245-1449

IDPA ID Number: 37-1120847001

Date of Initial License for Current Owners: 11/06/87

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
X "Sub-S" Corp.
Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MELVIN SIEGEL
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number THE ARC OF JACKSONVILLE LTD

0032938 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	93	Intermediate (ICF)	93	33,945	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	26,339	975		27,314	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,339	975		27,314	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.47%

D. How many bed-hold days during this year were paid by the Department? NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

I. On what date did you start providing long term care at this location? Date started 11/06/87

J. Was the facility purchased or leased after January 1, 1978? YES X Date 11/06/087 NO

K. Was the facility certified for Medicare during the reporting year? YES NO X If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID NumberTHE ARC OF JACKSONVILLE LTD#0032938Report Period Beginning:01/01/2005Ending:12/31/2005

Page 3

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	82,923	8,247	5,074	96,244		96,244		96,244			1
2	Food Purchase		102,834		102,834		102,834	(351)	102,483			2
3	Housekeeping	47,252	8,885		56,137		56,137		56,137			3
4	Laundry	27,959	8,143		36,102		36,102		36,102			4
5	Heat and Other Utilities			47,165	47,165		47,165	2,209	49,374			5
6	Maintenance	23,380		34,703	58,083		58,083	(2,665)	55,418			6
7	Other (specify):*			5,213	5,213		5,213	305	5,518			7
8	TOTAL General Services	181,514	128,109	92,155	401,778		401,778	(502)	401,276			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	479,380	11,292	11,062	501,734		501,734	9,775	511,509			10
10a	Therapy											10a
11	Activities	26,960	3,436	4,416	34,812		34,812	(4,416)	30,396			11
12	Social Services	91,437	600		92,037		92,037		92,037			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	597,777	15,328	15,478	628,583		628,583	5,359	633,942			16
	C. General Administration											
17	Administrative	118,695		3,000	121,695		121,695	2,830	124,525			17
18	Directors Fees											18
19	Professional Services			132,520	132,520		132,520	(105,549)	26,971			19
20	Dues, Fees, Subscriptions & Promotions			8,606	8,606		8,606	(302)	8,304			20
21	Clerical & General Office Expenses	26,795	8,609	26,859	62,263		62,263	40,236	102,499			21
22	Employee Benefits & Payroll Taxes			151,340	151,340		151,340		151,340			22
23	Inservice Training & Education							283	283			23
24	Travel and Seminar			5,774	5,774		5,774	8,569	14,343			24
25	Other Admin. Staff Transportation			15,677	15,677		15,677	5,422	21,099			25
26	Insurance-Prop.Liab.Malpractice			12,100	12,100		12,100	1,642	13,742			26
27	Other (specify):*			3,376	3,376		3,376	23,841	27,217			27
28	TOTAL General Administration	145,490	8,609	359,252	513,351		513,351	(23,028)	490,323			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	924,781	152,046	466,885	1,543,712		1,543,712	(18,171)	1,525,541			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	5,074
	REPAIRS & MAINTENANCE		0
			0
			5,074
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		11,551
	ELECTRICITY		23,611
	WATER		11,490
	CABLE TV - LOBBY		513
			0
			47,165
6	MAINTENANCE		
	GROUNDS MAINTENANCE		0
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE CONSULTANT		12,216
	EQUIPMENT MAINTENANCE & REPAIR		18,400
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		525
	FIRE SERVICE		3,562
			0
			0
			0
			34,703
7	OTHER		
	SCAVENGER		5,213
	SECURITY SERVICE		0
			5,213
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	0

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	6,916
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	746
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
	GERIATRIC CONSULTANT		3,400
			0
			11,062
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			0
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,416
			0
			4,416
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			0
			0
			0
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 3,000	3,000
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 9,278	
	ADMINISTRATIVE CONSULTANTS	XIX C 8,820	
	PROFESSIONAL FEES	XIX C 17,935	
	BOOKKEEPING/ADMINISTRATIVE SERVICES	96,487	132,520
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 27	
	EMPLOYEE WANT ADS	XIX F 1,736	
	CONTRIBUTIONS	VI 20 XIX F 180	
	DUES & SUBSCRIPTIONS	XIX F 4,974	
	LICENSES & PERMITS	XIX F 538	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 371	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 780	8,606
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	622	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 10,316	
	HOME OFFICE EXPENSE		
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	15,164	
	MESSENGER SERVICE	757	
		0	26,859

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 70,463	
	UNEMPLOYMENT COMPENSATION	XIX D 30,620	
	WORKERS COMPENSATION INSURANCE	XIX D 19,328	
	HOSPITALIZATION INSURANCE	XIX D 28,389	
	EMPLOYEE BENEFITS - OTHER	XIX D 2,540	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 0	151,340
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		0
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 1,690	
	TRAVEL	XIX G 4,084	
		0	
		0	5,774
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	15,677	15,677
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	12,100	12,100
27	OTHER		
	BAD DEBTS	VI 24 3,376	
			3,376

GRAND TOTAL COLUMN 3 OTHER

466,885

THE ARC OF JACKSONVILLE LTD
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	102,834	PATIENT MEALS	81942
LESS SALES TAX	(351)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	102,483	TOTAL MEALS/YEAR	81942
TOTAL PATIENT CENSUS	27,314	NET FOOD	102483
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	81942

TOTAL PATIENT MEALS	81942	COST PER MEAL	1.25
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			7,046	7,046		7,046	29,066	36,112			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,056	14,056		14,056	93,182	107,238			32
33	Real Estate Taxes			14,676	14,676		14,676		14,676			33
34	Rent-Facility & Grounds			110,481	110,481		110,481	(100,780)	9,701			34
35	Rent-Equipment & Vehicles			11,737	11,737		11,737	5,316	17,053			35
36	Other (specify):*											36
37	TOTAL Ownership			157,996	157,996		157,996	26,784	184,780			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,918	50,918		50,918		50,918			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			50,918	50,918		50,918		50,918			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	924,781	152,046	675,799	1,752,626		1,752,626	8,613	1,761,239			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,408	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(351)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(10,316)	21		18
19	Entertainment		20		19
20	Contributions	(551)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,376)	27		24
25	Fund Raising, Advertising and Promotional	(27)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (14,213)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	22,826		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 22,826		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 8,613		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Summary A

12/31/2005

[illegible]

Summary B

Facility Name & ID Number	THE ARC OF JACKSONVILLE LTD	#	0032938	Report Period Beginning:	01/01/2005	Ending:	12/31/2005
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												SUMMARY
Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS
D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)
Depreciation	1,408	0	444	27,214	0	0	0	0	0	0	0	29,066
Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0
Interest	0	0	1,282	91,900	0	0	0	0	0	0	0	93,182
Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0
Rent-Facility & Grounds	0	0	9,701	(110,481)	0	0	0	0	0	0	0	(100,780)
Rent-Equipment & Vehicles	0	0	5,316	0	0	0	0	0	0	0	0	5,316
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL Ownership	1,408	0	16,743	8,633	0	0	0	0	0	0	0	26,784
Ancillary Expense												
E. Special Cost Centers												
Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0
Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0
Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0
Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0
Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(14,213)	(96,511)	110,704	8,633	0	0	0	0	0	0	0	8,613

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		LITCHFIELD TERRACE	LITCHFIELD	MAVIN	SKOKIE, IL	CONSULTING
		RIVER VIEW MANOR	LOVES PARK	ENTERPRISES, LTD.		BOOKKEEPING
		PARKVIEW TERRACE	EAST MOLINE			
SEE ATTACHED SCHEDULE		GOLDEN MOMENTS	JACKSONVILLE	IDEA ASSOCIATES	SKOKIE, IL	REAL ESTATE
		SPRINGFIELD TERRACE	SPRINGFIELD			
		VANDALIA TERRACE	VANDALIA			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	MAINTENANCE CONSULTANT	\$ 12,216	MAVIN ENTERPRISES, LTD		\$	\$ (12,216)	1
2	V	10	PSYCHO-SOCIAL CONSULTANT	4,416				(4,416)	2
3	V	11	ACTIVITIES CONSULTANT	4,416				(4,416)	3
4	V	19	ADMIN. /BKBP. FEES	96,427				(96,427)	4
5	V	19	ADMIN. /CONSULT. FEES	8,820				(8,820)	5
6	V								6
7	V	5	ELECTRICITY/GAS				2,209	2,209	7
8	V	6	MAINTENANCE SALARIES				9,527	9,527	8
9	V	6	MAINTENANCE & REPAIR				24	24	9
10	V	7	SCAVENGER				305	305	10
11	V	10	PSYCH-SOCIAL & NURSING				14,191	14,191	11
12	V	17	ADMINISTRATIVE SALARIES				2,830	2,830	12
13	V	19	PROFESSIONAL FEES				698	698	13
14	Total			\$ 126,295			\$ 29,784	\$ * (96,511)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	ADVERTISING	\$	MAVIN ENTERPRISES, LTD.		\$ 276	\$ 276	15
16	V	21	TOTAL OFFICE				50,552	50,552	16
17	V	23	SEMINARS				283	283	17
18	V	24	TRAVEL				8,569	8,569	18
19	V	25	TRANSPORTATION				5,422	5,422	19
20	V	26	INSURANCE				1,642	1,642	20
21	V	27	EMPLOYEE BENEFITS				27,217	27,217	21
22	V	30	DEPRECIATION (SL)				444	444	22
23	V	32	INTEREST				1,282	1,282	23
24	V	34	OFFICE RENT				9,701	9,701	24
25	V	35	EQUIPMENT RENT				5,316	5,316	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 110,704	\$ * 110,704	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 110,481	IDEA ASSOCIATES		\$	(110,481)	15
16	V	30	DEPRECIATION				27,214	27,214	16
17	V	32	INTEREST				91,900	91,900	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 110,481			\$ 119,114	\$ * 8,633	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5					SEE ATTACHED SCHEDULE						5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number THE ARC OF JACKSONVILLE LTD # 0032938 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization MAVIN ENTERPRISES, LTD.
Street Address 3845 OAKTON
City / State / Zip Code SKOKIE, IL 60076
Phone Number (847) 679-0100
Fax Number (847) 679-0647

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	ELECTRICITY/GAS	PATIENT DAYS	143,350	7	\$ 11,595	\$	27,314	\$ 2,209	1
2	6	MAINTENANCE SALARIES	PATIENT DAYS	143,350	7	50,000	50,000	27,314	9,527	2
3	6	MAINTENANCE & REPAIR	PATIENT DAYS	143,350	7	128		27,314	24	3
4	7	SCAVENGER	PATIENT DAYS	143,350	7	1,602		27,314	305	4
5	10	PSYCH-SOCIAL & NURSING	PATIENT DAYS	143,350	7	74,480		27,314	14,191	5
6	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	143,350	7	14,850	14,850	27,314	2,830	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	143,350	7	3,665		27,314	698	7
8	20	ADVERTISING	PATIENT DAYS	143,350	7	1,451		27,314	276	8
9	21	TOTAL OFFICE	PATIENT DAYS	143,350	7	265,310	218,673	27,314	50,552	9
10	23	SEMINARS	PATIENT DAYS	143,350	7	1,485		27,314	283	10
11	24	TRAVEL	PATIENT DAYS	143,350	7	44,974		27,314	8,569	11
12	25	TRANSPORTATION	PATIENT DAYS	143,350	7	28,456		27,314	5,422	12
13	26	INSURANCE	PATIENT DAYS	143,350	7	8,617		27,314	1,642	13
14	27	EMPLOYEE BENEFITS	PATIENT DAYS	143,350	7	142,843		27,314	27,217	14
15	30	DEPRECIATION (SL)	PATIENT DAYS	143,350	7	2,332		27,314	444	15
16	32	INTEREST	PATIENT DAYS	143,350	7	6,726		27,314	1,282	16
17	34	OFFICE RENT	PATIENT DAYS	143,350	7	50,915		27,314	9,701	17
18	35	EQUIPMENT RENT	PATIENT DAYS	143,350	7	27,901		27,314	5,316	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 737,330	\$ 283,523		\$ 140,488	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	RELATED PARTY						\$		\$			\$	1		
2	IDEA ASSOCIATES												2		
3	BANK FINANCIAL		X	MORTGAGE	\$9,663.00	01/04		1,251,000	1,178,919		6.5000	91,900	3		
4													4		
5	MGMT ALLICATION											1,282	5		
	Working Capital														
6	SUCCESS NATINAL BANK		X	LINE OF CREDIT	DEMAND				346,992		PRIME +	14,056	6		
7													7		
8													8		
9	TOTAL Facility Related				\$9,663.00		\$	1,251,000	\$	1,525,911			\$	107,238	9
	B. Non-Facility Related*														
10													10		
11													11		
12													12		
13													13		
14	TOTAL Non-Facility Related						\$		\$			\$		14	
15	TOTALS (line 9+line14)						\$	1,251,000	\$	1,525,911			\$	107,238	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	21,066	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	17,782	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(3,284)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	17,960	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	14,676	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000	19,641	8	
		2001	20,191	9	
		2002	20,237	10	
		2003	20,857	11	
		2004	17,782	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				13	FROM R. E. TAX STATEMENT FOR 2004 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

THE ARC OF JACKSONVILLE LTD

COUNTY

MORGAN

FACILITY IDPH LICENSE NUMBER

0032938

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	09-29-103-018	NURSING HOME	\$ 17,782.10	\$ 17,782.10
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 17,782.10	\$ 17,782.10

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

Frame

Number of Stories

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1987	\$ 15,700	1
2					2
3	TOTALS			\$ 15,700	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	93		1987		\$ 857,227	\$ 27,214	31.5	\$ 27,214	\$	\$ 408,863	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS		1987		2,634	84	20	131	47	2,090	9
10	VARIOUS		1990		20,488	650	20	1,025	375	16,008	10
11	VARIOUS		1991		4,446	141	20	222	81	3,312	11
12	VARIOUS		1992		14,187	450	20	709	259	9,563	12
13	VARIOUS		1995		2,421	62	20	121	59	1,297	13
14	HEATER COVERS		1996		1,250	33	20	63	30	557	14
15	FLOOR TILE		1996		1,128	28	20	56	28	519	15
16	SMOKE DETECTORS		1996		929	23	20	46	23	458	16
17	TELEPHONE SYSTEM		1996		6,842	176	20	342	166	2,848	17
18	FLOOR TILE		1996		1,946	50	20	97	47	869	18
19	FLOOR TILE		1997		1,028	26	20	51	25	459	19
20	AIR HANDLERS & DUCTS		1997		3,725	95	20	186	91	1,625	20
21	CONDENSOR		1997		4,481	115	20	224	109	2,276	21
22	TILE		1997		3,410	88	20	170	82	1,437	22
23	DECORATING		1997		3,406	87	20	170	83	1,453	23
24	FENCE		1997		3,180	82	20	159	77	1,460	24
25	TILING		1997		2,740	70	20	137	67	1,119	25
26	SPRINKLER COMP		1997		825	21	20	41	20	331	26
27	CONCRETE SLAB APPROACH		1999		4,000	103	20	200	97	1,400	27
28	INSTALL RESIDENT CALL LIGHT SYSTEM		2000		16,698	607	27.5	607		3,337	28
29	ROOF REPAIR, INSTALLED DOWNSPOUT & GUTTER		2000		9,990	363	27.5	363		2,000	29
30	INSTALLED DOORS		2000		3,633	132	27.5	132		727	30
31	AIR CONDITIONERS		2000		1,477	55	27.5	55		300	31
32	BUMPER GUARDS, CAPS, HANDRAILS,BORDER TAGS		2000		10,952	398	27.5	398		2,192	32
33	REPAIR AUTOMATIC SPRINKLER SYSTEM		2000		3,422	124	27.5	124		679	33
34	TILE FOR B-HALL,COMPRESSOR FOR SPRINKLER SYSTEM		2001		1,621	59	27.5	59		266	34
35	FIRE ALARM EQUIPMENT FOR C-HALL		2001		3,168	115	27.5	115		518	35
36	INSTALLED TWO CAMERA'S, AIR CONDITIONERS		2001		2,244	82	27.5	82		369	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$993,498	\$31,533		\$33,299	\$1,766	\$468,332	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$22,380	\$2,183	\$2,233	\$50	8-10 YRS	\$12,339	71
72	Current Year Purchases	2,722	544	136	(408)	10 YRS	136	72
73	Fully Depreciated Assets	24,022					24,022	73
74	MGMT ALLOCATION		444	444				74
75	TOTALS	\$49,124	\$3,171	\$2,813	\$(358)		\$36,497	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	FACILITY	1986 FORD TRUCK	1996	\$2,300	\$	\$	\$		\$2,300
77									
78									
79									
80	TOTALS			\$2,300	\$	\$	\$		\$2,300

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	1,060,622
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	34,704
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	36,112
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	1,408
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	507,129

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 8,660 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	1997 FORD WAGON	\$ 251.00	\$ 3,077	17
18					18
19					19
20					20
21	TOTAL		\$ 251.00	\$ 3,077	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED	
COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits			N/A				6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,155	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	378,800		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,509		6
7	Other Prepaid Expenses	2,500		7
8	Accounts Receivable (owners or related parties)	1,986,125		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,438,089	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	139,249		15
16	Equipment, at Historical Cost	48,444		16
17	Accumulated Depreciation (book methods)	(89,655)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	3,333		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 101,371	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,539,460	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 664,059	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	711,620		29
30	Accrued Salaries Payable	24,664		30
31	Accrued Taxes Payable (excluding real estate taxes)	207,113		31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,960		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,625,416	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,625,416	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 914,044	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,539,460	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 683,469	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	1,085	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 684,554	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	229,490	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 229,490	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 914,044	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,982,116	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,982,116	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,982,116	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	401,778	31
32	Health Care	628,583	32
33	General Administration	513,351	33
	B. Capital Expense		
34	Ownership	157,996	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	50,918	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,752,626	40
41	Income before Income Taxes (line 30 minus line 40)**	229,490	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 229,490	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,928	2,095	\$ 48,321	\$ 23.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,208	1,425	23,164	16.26	3
4	Licensed Practical Nurses	9,711	10,271	155,260	15.12	4
5	CNAs & Orderlies	22,995	24,312	205,012	8.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,516	3,730	26,960	7.23	10
11	Social Service Workers	7,480	8,198	91,437	11.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,660	11,152	82,923	7.44	15
16	Dishwashers					16
17	Maintenance Workers	2,014	2,268	23,380	10.31	17
18	Housekeepers	6,863	7,169	47,252	6.59	18
19	Laundry	3,639	4,035	27,959	6.93	19
20	Administrator	3,792	4,255	118,695	27.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,939	4,119	26,795	6.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	2,652	3,141	47,623	15.16	33
34	TOTAL (lines 1 - 33)	80,397	86,170	\$ 924,781 *	\$ 10.73	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 5,074	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	746	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	4,416	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	E			46
47	PSYCHO-SOCIAL CONSULTANT	S	6,916	10-3	47
48	GERIATRIC CONSULTANT		3,400	10-3	48
49	TOTAL (lines 35 - 48)		\$ 20,552		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
CAIN SMITH	ADMIN	0	\$ 53,470
BOBI SMITH	ADM. CONS.	0	65,225
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 118,695
B. Administrative - Other			
Description			Amount
MELVIN SIEGEL	MANAGEMENT FEES	\$	3,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 3,000
C. Professional Services			
Vendor/Payee	Type		Amount
KBKB	ACCOUNTING	\$	10,250
GENSON & GILLESPIE	LEGAL FEES		1,000
GARY A. WEINTRAUB	LEGAL FEES		5,200
PERSONNEL PLANNERS	U.C. CONSULTANT		1,485
LTC SOLUTIONS	DATA PROCESSING		1,320
NURSING CARE SYSTEMS	DATA PROCESSING		5,016
ALPHA DATA SERVICES	DATA PROCESSING		2,294
BKD TECHNOLOGIES	DATA PROCESSING		648
MAVIN ENTERPRISES	ADMIN. CONSULTANT		8,820
MAVIN ENTERPRISES	BOOKKEEPING/ADMIN		96,427
SAK MANAGEMENT	BOOKKEEPING/ADMIN		60
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 132,520
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	19,328
Unemployment Compensation Insurance			30,620
FICA Taxes			70,463
Employee Health Insurance			28,389
Employee Meals			0
Illinois Municipal Retirement Fund (IMRF)*			
EMPLOYEE BENEFITS - OTHER			2,540
EMPLOYEE PHYSICAL EXAMS			0
PENSION/PROFIT SHARING PLANS			0
CHICAGO HEAD TAX			0
INSURANCE - EXECUTIVE LIFE			0
INSURANCE - EXECUTIVE LIFE VI 21			0
TOTAL (agree to Schedule V, line 22, col.8)			\$ 151,340
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			1,736
Health Care Worker Background Check (Indicate # of checks performed 55)			780
MARKETING/ADV/PROMO			27
TRUST/FRANCHISE/CONTRIB/ETC			551
LICENSES & PERMITS			538
DUES & SUBSCRIPTIONS			4,974
MGMT CO ALLOCATION			276
TRUST/FRANCHISE/CONTRIB/ETC			(551)
Less: Public Relations Expense	(0)
Non-allowable advertising			(27)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 8,304
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
			4,084
MGMT ALLOCATION			8,569
Seminar Expense			
			1,690
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	14,343

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number		THE ARC OF JACKSONVILLE LTD		STATE OF ILLINOIS	#	0032938	Report Period Beginning:	01/01/2005	Ending:	12/31/2005	Page 23
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XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

NO

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

YES
IL COUNCIL ON LONG TERM CARE \$4,774

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

YES
YES

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

NO

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

YES
10 YR

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 0 Line 10-2

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

YES

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

NO

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 50,918

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

NO

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

YES

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

NO

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Indicate the amount. \$

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

NO

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

NO

c.

What percent of all travel expense relates to transportation of nurses and patients?

5%

d.

Have vehicle usage logs been maintained?

NO

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

NO

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

YES

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

NO
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?
If no, please explain.

NO

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

YES

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees

YES